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12VAC30-90-135. Reimbursement of legal fees associated with appeals having substantial merit.

A. The Department of Medical Assistance Services shall reimburse a nursing facility for reasonable and necessary legal fees associated with an informal or formal appeal brought pursuant to the Administrative Process Act, only if the nursing facility substantially prevails on the merit of the appeal. The term "substantially prevails" is defined as being successful on more than 50% of the issue as appealed and on more than 50% of the amount under appeal. The reimbursement of legal fees remains subject to the State Plan for Medical Assistance and all existing ceilings. Any legal fees claimed must be supported by adequate, detailed, and verifiable documentation.

B. Subject to the requirements of subsection A of this section, the reimbursable legal fees will be included in the calculation of total allowable costs in the fiscal year the appeal process is concluded and Medicaid will reimburse the nursing facility for its Medicaid proportionate share.

12VAC30-90-136. Elements of the capital payment methodology that shall not be subject to appeal shall be:

1. The definitions provided in this section, and the application of those definitions to the FRV rate calculation.

2. The transition policy described in this section.

3. The formula for determining the FRV per diem rate described in this section.

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4. The calculation of the FRV rental amount described in this section.

5. The exclusion of certain beds from the transition policy, as provided in this section.

6. The adjustment for FRV savings during the transition.

12VAC30-90-137 to 12VAC30-90-139. Reserved

Subpart IV

Individual Expense Limitation

12VAC30-90-140. Individual expense limitation.

In addition to operating costs being subject to peer group ceilings, costs are further subject to maximum limitations as defined in 12VAC30-90-290, Cost Reimbursement Limitations.

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Subpart V

Cost Report Preparation Instructions

12VAC30-90-150. Cost report preparation instructions.

Instructions for preparing NF cost reports will be provided by the DMAS.

Subpart VI

Stock Transactions

12VAC30-90-160. Stock acquisition; merger of unrelated and related parties.

A. Any cost associated with an acquisition of capital stock shall not be an allowable cost.

B. In the case of a merger which combines two or more unrelated corporations under the regulations of the Code of Virginia, there will be only one surviving corporation. If the surviving corporation, which will own the assets and liabilities of the merged corporation, is not a provider, a Certificate of Public Need, if applicable, must be issued to the surviving corporation.

The nonsurviving corporation shall be subject to the policies applicable to terminated providers, including those relating to gain or loss on sales of NFs.

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C. The statutory merger of two or more related parties or the consolidation of two or more related providers resulting in a new corporate entity shall be treated as a transaction between related parties. No revaluation shall be permitted for the surviving corporation.

Subpart VII

Nurse Aide Training and Competency Evaluation Program and Competency Evaluation Programs (NATCEPs)

12VAC30-90-170. NATCEPs costs.

A. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) amended § 1903(a)(2)(B) of the Social Security Act to fund actual NATCEPs costs incurred by NFs separately from the NF's medical assistance services reimbursement rates.

B. NATCEPs costs shall be as defined in 12VAC30-90-270.

C. To calculate the reimbursement rate, NATCEPs costs contained in the most recently filed cost report shall be converted to a per diem amount by dividing allowable NATCEPs costs by the actual number of NF's patient days.

D. The NATCEPs interim reimbursement rate determined in subsection C of this section shall be added to the prospective operating cost and plant cost components or charges, whichever is lower, to determine the NF's prospective rate. The NATCEPs interim reimbursement rate shall not be adjusted for inflation.

E. Reimbursement of NF costs for training and competency evaluation of nurse aides must take into account the NF's use of trained nurse aides in caring for Medicaid, Medicare and private pay patients. Medicaid shall not be charged for that portion of NATCEPs costs which are properly charged to Medicare or private pay services. The final retrospective reimbursement for NATCEPs costs shall be the reimbursement rate as calculated from the most recently filed cost report by the methodology in subsection C of this section times the Medicaid patient days from the DMAS MMR-240.

F. Disallowance of nonreimbursable NATCEPs costs shall be reflected in the year in which the nonreimbursable costs were claimed.

G. Payments to providers for allowable NATCEPs costs shall not be considered in the comparison of the lower allowable reimbursement or charges for covered services, as outlined in 12VAC30-90-55 A.

Subpart VIII

Criminal Records Checks for Nursing Facility Employees

12VAC30-90-180. Criminal records checks.

A. This section implements the requirements of § 32.1-126.01 of the Code of Virginia and Chapter 994 of the Acts of Assembly of 1993 (Item 313 T).

B. A licensed nursing facility shall not hire for compensated employment persons who have been convicted of:

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1. Murder; .

2. Abduction for immoral purposes as set out in § 18.2-48 of the Code of Virginia; .

3. Assaults and bodily woundings as set out in Article 4 (§ 18.2-51 et seq.) of Chapter 4 of Title 18.2 of the Code of Virginia; .

4. Arson as set out in Article 1 (§ 18.2-77 et seq.) of Chapter 5 of Title 18.2 of the Code of Virginia; .

5. Pandering as set out in § 18.2-355 of the Code of Virginia; .

6. Crimes against nature involving children as set out in § 18.2-361 of the Code of Virginia; .

7. Taking indecent liberties with children as set out in §§ 18.2-370 or 18.2-370.1 of the Code of Virginia; .

8. Abuse and neglect of children as set out in § 18.2-371.1 of the Code of Virginia; .

9. Failure to secure medical attention for an injured child as set out in § 18.2-314 of the Code of Virginia; .

10. Obscenity offenses as set out in §18.2-374.1 of the Code of Virginia; or .

11. Abuse or neglect of an incapacitated adult as set out in § 18.2-369 of the Code of Virginia.

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C. The provider shall obtain a sworn statement or affirmation from every applicant disclosing any criminal convictions or pending criminal charges for any of the offenses specified in subsection B of this section regardless of whether the conviction or charges occurred in the Commonwealth.

D. The provider shall obtain an original criminal record clearance or an original criminal record history from the Central Criminal Records Exchange for every person hired. This information shall be obtained within 30 days from the date of employment and maintained in the employees' files during the term of employment and for a minimum of five years after employment terminates for whatever reason.

E. The provider may hire an applicant whose misdemeanor conviction is more than five years old and whose conviction did not involve abuse or neglect or moral turpitude.

F. Reimbursement to the provider will be handled through the cost reporting form provided by the DMAS and will be limited to the actual charges made by the Central Criminal Records Exchange for the records requested. Such actual charges will be a pass-through cost which is not a part of the operating or plant cost components.

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Subpart IX

Use of MMR-240

12VAC30-90-190. Use of MMR-240.

All providers must use the data from computer printout MMR-240 based upon a 60-day accrual period.

Subpart X

Commingled Investment Income

12VAC30-90-200. Commingled investment income.

DMAS shall treat funds commingled for investment purposes in accordance with PRM-15, § 202.6.

Subpart XI

Provider Notification

12VAC30-90-210. Provider notification.

DMAS shall notify providers of State Plan changes affecting reimbursement 30 days prior to the enactment of such changes.

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Subpart XII

Start-up Costs and Organizational Costs

12VAC30-90-220 through 12VAC30-90-222. Repealed.

12VAC30-90-223 to 12VAC30-90-229. Reserved

Subpart XIII

DMAS Authorization

12VAC30-90-230. Access to records.

A. DMAS shall be authorized to request and review, either through a desk or field audit, all information related to the provider's cost report that is necessary to ascertain the propriety and allocation of costs (in accordance with Medicare and Medicaid rules, regulations, and limitations) to patient care and nonpatient care activities. 12VAC30-90-222.

B. Examples of such information shall include, but not be limited to, all accounting records, mortgages, deeds, contracts, meeting minutes, salary schedules, home office services, cost reports, and financial statements.

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C. This access also applies to related organizations as defined in 12VAC30-90-51 who provide assets and other goods and services to the provider.

Subpart XIV

Home Office Costs

12VAC30-90-240. Home office costs.

A. Home office costs shall be allowable to the extent they are reasonable, relate to patient care, and provide cost savings to the provider.

B. Provider purchases from related organizations, whether for services, or supplies, shall be limited to the lower of the related organizations actual cost or the price of comparable purchases made elsewhere.

C. Home office costs shall be allocated in accordance with § 2150.3, PRM-15.

D. Home office costs associated with providing management services to non-related entities shall not be recognized as allowable reimbursable cost.

E. Allowable and non-allowable home office costs shall be recognized in accordance with § 2150.2, PRM-15.

F. Item 398 D Chapter 723 of 1987 Acts of Assembly (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers for periods or portions thereof on or after July 1, 1987.

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Subpart XV

Refund of Overpayments

12VAC30-90-250. Lump sum payment.

When the provider files a cost report indicating that an overpayment has occurred, full refund shall be remitted with the cost report. In cases where DMAS discovers an overpayment during desk audit, field audit, or final settlement, DMAS shall promptly send the first demand letter requesting a lump sum refund. Recovery shall be undertaken even though the provider disputes in whole or in part DMAS' determination of the overpayment.

12VAC30-90-251. Offset.

If the provider has been overpaid for a particular fiscal year and has been underpaid for another fiscal year, the underpayment shall be offset against the overpayment. So long as the provider has an overpayment balance, any underpayments discovered by subsequent review or audit shall be used to reduce the balance of the overpayment.

12VAC30-90-252. Payment schedule.

A. If the provider cannot refund the total amount of the overpayment (i) at the time it files a cost report indicating that an overpayment has occurred, the provider shall request in

writing an extended repayment schedule at the time of filing, or (ii) within 30 days after receiving the DMAS demand letter, the provider shall promptly request in writing an extended repayment schedule.

B. DMAS may establish a repayment schedule of up to 12 months to recover all or part of an overpayment or, if a provider demonstrates that repayment within a 12-month period would create severe financial hardship, the Director of DMAS may approve a repayment schedule of up to 36 months.

C. A provider shall have no more than one extended repayment schedule in place at one time. If subsequent audits identify additional overpayment, the full amount shall be repaid within 30 days unless the provider submits further documentation supporting a modification to the existing extended repayment schedule to include the additional amounts.

D. If, during the time an extended repayment schedule is in effect, the provider ceases to be a participating provider or fails to file a cost report in a timely manner, the outstanding balance shall become immediately due and payable.

E. When a repayment schedule is used to recover only part of an overpayment, the remaining amount shall be recovered from interim payments to the provider or by lump sum payments.

12VAC30-90-253. Extension request documentation.

In the written request for an extended repayment schedule, the provider shall document the need for an extended (beyond 30 days) repayment and submit a written proposal

scheduling the dates and amounts of repayments. If DMAS approves the schedule, DMAS shall send the provider written notification of the approved repayment schedule, which shall be effective retroactive to the date the provider submitted the proposal.

12VAC30-90-254. Interest charge on extended repayment.

A. Once an initial determination of overpayment has been made, DMAS shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. If an appeal follows, interest shall be waived during the period of administrative appeal of an initial determination of overpayment.

B. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 of the Code of Virginia from the date the director's determination becomes final.

C. The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest which the provider paid to DMAS.

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12VAC30-90-255 to 12VAC30-90-259. Reserved

Subpart XVI

Revaluation of Assets

12VAC30-90-260. Repealed.

12VAC30-90-264. Specialized care services.

Specialized care services provided in conformance with 12VAC30-60-40 E and H, 12VAC30-60-320 and 12VAC30-60-340 shall be reimbursed under the following methodology. The nursing facilities that provide adult specialized care for the categories of Ventilator Dependent Care, Comprehensive Rehabilitation Care, and Complex Health Care will be placed in one group for rate determination. The nursing facilities that provide pediatric specialized care in a dedicated pediatric unit of eight beds or more will be placed in a second group for rate determination.

1. Routine operating cost. Routine operating cost shall be defined as in 12VAC30-90-271 and 12VAC30-90-272. To calculate the routine operating cost reimbursement rate, routine operating cost shall be converted to a per diem amount by dividing it by actual patient days. .

2. Allowable cost identification and cost reimbursement limitations. The provisions of Article 3 (12VAC30-90-50 et seq.) of Part II of this chapter and of Appendix III

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(12VAC30-90-290) of Part III of this chapter shall apply to specialized care cost and reimbursement. .

3. Routine operating cost rates. Each facility shall be reimbursed a prospective rate for routine operating costs. This rate will be the lesser of the facility-specific prospective routine operating ceiling, or the facility-specific prospective routine operating cost per day plus an efficiency incentive. This efficiency incentive shall be calculated by the same method as in 12VAC30-90-41. .

4. Facility-specific prospective routine operating ceiling. Each nursing facility's prospective routine operating ceiling shall be calculated as:

   a. Statewide ceiling. The statewide routine operating ceiling shall be the weighted average (weighted by 1994 days) of specialized care rates in effect on July 1. 1996, reduced by statewide weighted average ancillary and capital cost per day amounts based on audited 1994 cost data from the 12 facilities whose 1994 FY specialized care costs were audited during 1996. This routine operating ceiling amount shall be adjusted for inflation by the percentage of change in the moving average of the Virginia specific Skilled Nursing Facility Market Basket of Routine Service Costs, as developed by DRI/McGraw-Hill, using the second quarter 1996 DRI table. The respective statewide operating ceilings will be adjusted each quarter in which the provider's most recent fiscal year ends, by adjusting the most recent interim ceiling by 100% of historical inflation and 50% of forecasted inflation to the end of the provider's next fiscal year.

   b. The portion of the statewide routine operating ceiling relating to nursing salaries (as determined by the 1994 audited cost report data, or 67.22%) will be wage adjusted using a normalized wage index. The normalized wage index shall be the

wage index applicable to the individual provider's geographic location under Medicare rules of reimbursement for skilled nursing facilities, divided by the statewide average of such wage indices across the state. This normalization of wage indices shall be updated January 1, after each time the Health Care Financing Administration (HCFA) publishes wage indices for skilled nursing facilities. Updated normalization shall be effective for fiscal years starting on and after the January 1 for which the normalization is calculated.

c. The percentage of the statewide routine operating ceiling relating to the nursing labor and non-labor costs (as determined by the 1994 audited cost report data or 71.05%) will be adjusted by the nursing facility's specialized care average Resource Utilization Groups, Version III (RUG-III) Nursing-Only Normalized Case Mix Index (NCMI). The NCMI for each nursing facility will be based on all specialized care patient days rendered during the six-month period prior to that in which the ceiling applies (see subdivision 6 below).

5. Normalized case mix index (NCMI). Case mix shall be measured by RUG-III nursing-only index scores based on Minimum Data Set (MDS) data. The RUG-III nursing-only weights developed at the national level by the Health Care Financing Administration (HCFA) (see 12VAC30-90-320) shall be used to calculate a facility-specific case mix index (CMI). The facility-specific CMI, divided by the statewide CMI shall be the facility's NCMI. The steps in the calculation are as follows:

a. The facility-specific CMI for purposes of this rate calculation shall be the average of the national RUG-III Nursing-Only weights calculated across all patient days in the facility during the six months prior to the six-month period to which the NCMI shall be applied to the facility's routine operating cost and ceiling.

b. The statewide CMI for purposes of this rate calculation shall be the average of the national RUG-III Nursing-Only weights calculated across all specialized care patient days in all Specialized Care Nursing facilities in the state during the six months prior to the six-month period to which the NCMI shall be applied. A new statewide CMI shall be calculated for each six-month period for which a provider-specific rate must be set.

c. The facility-specific NCMI for purposes of this rate calculation shall be the facility-specific CMI from (a) above divided by the statewide CMI from (b) above.

d. Each facility's NCMI shall be updated semiannually, at the start and the midpoint of the facility's fiscal year.

e. Patient days for which the lowest RUG-III weight is imputed, as provided in subdivision 14 c of this section, shall not be included in the calculation of the NCMI.

6. Facility-specific prospective routine operating base cost per day: The facility-specific routine operating cost per day to be used in the calculation of the routine operating rate and the efficiency incentive shall be the actual routine cost per day from the most recent fiscal year's cost report, adjusted (using DRI-Virginia inflation factors) by 50% of historical inflation and 50% of the forecasted inflation, and adjusted for case mix as described below:

a. An NCMI rate adjustment shall be applied to each facility's prospective routine nursing labor and non-labor operating base cost per day for each semiannual period of the facility's fiscal year.

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b. The NCMI calculated for the second semiannual period of the previous fiscal year shall be divided by the average of that (previous) fiscal year's two semiannual NCMIs to yield an "NCMI cost rate adjustment" to the prospective nursing labor and non-labor operating cost base rate in the first semiannual period of the subsequent fiscal year.

c. The NCMI determined in the first semiannual period of the subsequent fiscal year shall be divided by the average of the previous fiscal year's two semiannual NCMIs to determine the NCMI cost rate adjustment to the prospective nursing labor and non-labor operating base cost per day in the second semiannual period of the subsequent fiscal year.

See 12VAC30-90-310 for an illustration of how the NCMI is used to adjust routine operating cost ceilings and semiannual NCMI adjustments to the prospective routine operating base cost rates.

7. Interim rates. Interim rates, for processing claims during the year, shall be calculated from the most recent settled cost report and Minimum Data Set (MDS) data available at the time the interim rates must be set, except that failure to submit cost and MDS data timely may result in adjustment to interim rates as provided elsewhere. .

8. Ancillary costs. Specialized care ancillary costs will be paid on a pass-through basis for those Medicaid specialized care patients who do not have Medicare or any other sufficient third-party insurance coverage. Ancillary costs will be reimbursed as follows:

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a. All covered ancillary services, except kinetic therapy devices, will be reimbursed for reasonable costs as defined in the current NHPS. See 12VAC30-90-290 for the cost reimbursement limitations.

b. Kinetic therapy devices will have a limit per day (based on 1994 audited cost report data inflated to the rate period). See 12VAC30-90-290 for the cost reimbursement limitations.

c. Kinetic therapy devices will be reimbursed only if a resident is being treated for wounds that meet specialized care Complex Health Care Category wound care criteria. Residents receiving this wound care must require kinetic bed therapy (that is, low air loss mattresses, fluidized beds, and/or rotating/turning beds) and require treatment for a grade (stage) IV decubitus, a large surgical wound that cannot be closed, or second to third degree burns covering more than 10% of the body.

9. Covered ancillary services are defined as follows: laboratory, X-ray, medical supplies (e.g., infusion pumps, incontinence supplies), physical therapy, occupational therapy, speech therapy, inhalation therapy, IV therapy, enteral feedings, and kinetic therapy. The following are not specialized care ancillary services and are excluded from specialized care reimbursement: physician services, psychologist services, total parenteral nutrition (TPN), and drugs. These services must be separately billed to DMAS. An interim rate for the covered ancillary services will be determined (using data from the most recent settled cost report) by dividing allowable ancillary costs by the number of patient days for the same cost reporting period. The interim rate will be retroactively cost settled based on the specialized care nursing facility cost reporting period.

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10. Capital costs. Effective July 1, 2000, capital cost reimbursement shall be in accordance with 12 VAC 30-90-35 through 12 VAC 30-90-37 inclusive of the NHPS, except that the 90% occupancy requirement shall not be separately applied to specialized care. Capital cost related to specialized care patients will be cost settled on the respective nursing facility's cost reporting period. In this cost settlement the 90% occupancy requirement shall be applied to all the nursing facility's licensed nursing facility beds inclusive of specialized care. .

11. Nurse aide training and competency evaluation programs and competency evaluation programs (NATCEP) costs. NATCEPS costs will be paid on a pass-through basis in accordance with the current NHPS. .

12. Pediatric routine operating cost rate. For pediatric specialized care in a distinct part pediatric specialized care unit, one routine operating cost ceiling will be developed. The routine operating cost ceiling will be computed as follows: .

    a. The Complex Health Care Payment Rate effective July 1, 1996, and updated for inflation, will be reduced by (i) the weighted average capital cost per day developed from the 1994 audit data and (ii) the weighted average ancillary cost per day from the 1994 audit data updated for inflation in the same manner as described in subdivision 4 a of this subsection.

    b. The statewide operating ceiling shall be adjusted for each nursing facility in the same manner as described in subdivisions 4 and 5 of this section.

    c. The final routine operating cost reimbursement rate shall be computed as described for other than pediatric units in subdivision 3 of this section.

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13. Pediatric unit capital cost. Pediatric unit capital costs will be reimbursed in accordance with the current NHPS, except that the occupancy requirement shall be 70% rather than 90%.

14. MDS data submission. MDS data relating to specialized care patients must be submitted to the department in a submission separate from that which applies to all nursing facility patients.

    a. Within 30 days of the end of each month, each specialized care nursing facility shall submit to the department, separately from its submission of MDS data for all patients, a copy of each MDS Version 2.0 which has been completed in the month for a Medicaid specialized care patient in the nursing facility. This shall include (i) the MDS required within 14 days of admission to the nursing facility (if the patient is admitted as a specialized care patient), (ii) the one required by the department upon admission to specialized care, (iii) the one required within 12 months of the most recent full assessment, and (iv) the one required whenever there is a significant change of status.

    b. In addition to the monthly data submission required in (a) above, the same categories of MDS data required in (a) above shall be submitted for all patients receiving specialized care from January 1, 1996, through December 31, 1996, and shall be due February 28, 1997.

    c. If a provider does not submit a complete MDS record for any patient within the required timeframe, the department shall assume that the RUG-III weight for that patient, for any time period for which a complete record is not provided, is the lowest RUG-III weight in use for specialized care patients. A complete MDS

record is one that is complete for purposes of transmission and acceptance by the Health Care Financing Administration.

15. Case mix measures in the initial semiannual periods. In any semiannual periods for which calculations in 12VAC39-90-310 requires an NCMI from a semiannual period beginning before January 1996, the case mix used shall be the case mix applicable to the first semiannual period beginning after January 1, 1996, that is a semiannual period in the respective provider's fiscal period. For example, December year-end providers' rates applicable to the month of December 1996, would normally require (in Appendix I (12VAC30-90-270 et seq.) of Part III of this chapter) an NCMI from July to December 1995, and one from January to June 1996, to calculate a rate for July to December 1996. However, because this calculation requires an NCMI from a period before January 1996, the NCMIs that shall be used will be those applicable to the next semiannual period. The NCMI from January to June 1996, and from July to December 1996, shall be applied to December 1996, as well as to January to June 1997. Similarly, a provider with a March year end would have it's rate in December 1996, through March 1997, calculated based on an NCMI from April through September 1996, and October 1996, through March 1997. .

16. Cost reports of specialized care providers are due not later than 150 days after the end of the provider's fiscal year. Except for this provision, the requirements of 12VAC30-90-70 and 12VAC30-90-80 shall apply.

12VAC30-90-266. Traumatic Brain Injury (TBI) payment.

DMAS shall provide a fixed per day payment for nursing facility residents with TBI served in the program in accordance with resident and provider criteria, in addition to the

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reimbursement otherwise payable under the provisions of the Nursing Home Payment System. Effective for dates of service on and after August 19, 1998, a per day rate add-on shall be paid for recipients who meet the eligibility criteria for these TBI payments and who are residents in a designated nursing facility TBI unit of 20 beds or more that meets the provider eligibility criteria. The value of the rate add-on shall be $22 on August 19, 1998, and thereafter. The rate add-on for any qualifying provider's fiscal year shall be reviewed annually to determine the appropriateness of the amount, and any changes will be published and distributed to the providers. (Refer to 12VAC30-90-330, Traumatic brain injury diagnoses, for related resident and provider requirements.)